DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 303-D
200 Independence Avenue, SW
Washington, DC 20201

Public Affairs Office

MEDICARE FACT SHEET

Contact: CMS Press Office
(202) 690-6145

MEDICARE HEALTH SUPPORT TO IMPROVE CARE OF BENEFICIARIES WITH CHRONIC ILLNESSES

Overview: *Section 721 of the Medicare Modernization Act of 2003 (MMA) authorized development and testing of voluntary chronic care improvement programs, now called Medicare Health Support, to improve the quality of care and life for people living with multiple chronic illnesses. The programs will help participants adhere to their physicians' plans of care and obtain the medical care they need to reduce their health risks. Chronic conditions are a leading cause of illness, disability, and death among Medicare beneficiaries and account for a disproportionate share of health care expenditures. About 14 percent of Medicare beneficiaries have congestive heart failure but they account for 43 percent of Medicare spending. About 18 percent of Medicare beneficiaries have diabetes, yet they account for 32 percent of Medicare spending. By better managing and coordinating the care of these beneficiaries, the new Medicare initiative will help reduce health risks, improve quality of life, and provide savings to the program and the beneficiaries. The programs will be overseen by the Centers for Medicare & Medicaid Services and operated by health care organizations chosen through a competitive selection process. The first program is expected to be operational in the summer of 2005 with others to follow.*

Participants: Phase I of Medicare Health Support will serve approximately 180,000 Medicare beneficiaries who are enrolled in traditional fee-for-service Medicare and who have congestive heart failure and complex diabetes among their chronic conditions. Participation is voluntary and free to participating beneficiaries. This service will not affect a beneficiary's ability to choose their own doctors and other health care providers, and will support compliance with physician orders. Medicare benefits will not change as a result of participation in a Medicare Health Support program.

Using historical claims data, CMS will identify beneficiaries by geographic area and screen them for Medicare Health Support eligibility. Targeted beneficiaries will be assigned randomly to either an intervention group or a control group. Those in the intervention group will be notified of the opportunity to participate through a letter from the Medicare program. The letter will describe the program and give the beneficiary the opportunity to decline to be contacted by a Medicare Health Support organization if he or she does not want to participate.

Program operations: Each of the local Medicare Health Support organizations will offer self-care guidance and support to chronically ill Medicare beneficiaries to help them manage their health, adhere to their physicians' plans of care, and ensure that they seek and obtain the medical care and Medicare-covered benefits that they need. Medicare Health Support will include collaboration with participants' health care providers to enhance communication of relevant clinical information. The programs are intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits, and help participants avoid costly and debilitating complications. The organizations operating the programs are required to assist participants in managing their health holistically, including all co-morbidities, relevant health care services, and pharmaceutical needs as well as unique individual needs and cognitive impairments.

Organizations and Locations: Phase I pilot programs will be operated by Aetna Health Management in Chicago; American Healthways Inc. in the District of Columbia and Maryland; CIGNA HealthCare in Georgia; Health Dialog Services Corporation in Pennsylvania; Humana, Inc. in Central Florida; LifeMasters Supported SelfCare, Inc. in Oklahoma; McKesson Health Solutions in Mississippi; Visiting Nurse Service of New York in partnership with United HealthCare Services, Inc.-Evercare in Queens and Brooklyn in New York City; and XLHealth in Tennessee.

The areas to be served have high prevalence of diabetes and congestive heart failure among Medicare beneficiaries. The areas represent a mix of rural and urban areas and include ethnically and culturally diverse populations.

Phase I and Phase II: Medicare Health Support is designed as a two-phased initiative. Phase I is a pilot phase that will operate for three years and be evaluated through randomized controlled trials. Phase II is the expansion phase. The Secretary of HHS is authorized by MMA to precede with Phase II expansion within two to three and a half years after Phase I, if the Secretary finds that the conditions for expansion laid out in the statute have been met. In Phase II, the Secretary may expand Phase I programs or program components that have proven to be successful in improving clinical outcomes, increasing beneficiary satisfaction, and meeting Medicare spending targets for their assigned populations.

###